2006 WL 6451728 (Hawai'i Cir.Ct.) (Trial Motion, Memorandum and Affidavit)
Circuit Court of Hawai'i.
First Circuit
Honolulu County

The DEPARTMENT OF HUMAN SERVICES, State of Hawaii, Appellant,

v.

Nuuanu HALE; Lillian Koller, Director of the Department of Human Services, State of Hawaii, Appellees.

No. 05-1-2125-11 (EEH).
March 1, 2006.

Oral Argument Date: May 10, 2006
Time: 9:15 a.m.

Appellant's Opening Brief; Certificate of Service

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Judge: Eden Elizabeth Hifo.

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Appellant Department of Human Services, State of Hawaii ("DHS") by and through its attorneys Mark J. Bennett, Attorney General, and Heidi M. Rian and Candace J. Park, Deputy Attorneys General, pursuant to section 91-14, Hawaii Revised Statutes ("HRS"), appeals to the Circuit Court of the First Circuit of the State of Hawaii from the administrative hearing decision issued October 31, 2005.

In the October 31, 2005 hearing decision, the hearing officer reversed DHS' determination that Appellee Nuuanu Hale failed to provide Client A, a seventy-nine year old female resident of the Nuuanu Hale nursing home facility, who had a foley catheter inserted into her urethra for over six months, with the level of care that the reasonable caregiver would have provided. The hearing officer's decision is clearly erroneous because there is substantial evidence in the record to support DHS' confirmation of neglect by Nuuanu Hale of Client A based upon the undisputed condition of Client A's infected vaginal area upon being admitted to the St. Francis Medical Center emergency room on March 5, 2004:

- **Severe vaginal lesion with discharge and skin necrosis,**
- **The "whole" vaginal area reported to be "enlarged and pussy," and**
- **Two possible holes in the urethra.**

DHS respectfully requests this Court to reverse the October 31, 2005 administrative decision.

I. POINTS OF ERROR.

A.The hearing officer erred in reversing DHS' determination of neglect because there is substantial evidence in the record to support DHS' determination that Nuuanu Hale failed to provide Client A with the degree of care that a reasonable care facility would have provided.

B. hearing officer erred in his determination that the preponderance of the "evidence and testimony supports [Nuuanu Hale's] position that the nursing staff observed and recorded any abnormalities with respect to Client A's genital and perineal area." ROA 22.

C. The hearing officer erred in his determination that the preponderance of the evidence supports Nuuanu Hale's contention that the "swift deterioration of Client A's condition" was due to an "extremely weak immune system that permitted the bullous pemphigoid to spread at a rapid rate and result in purulent and necrosis at the time Client A entered St. Francis hospital on March 5, 2004." ROA 23.

D. The hearing officer erred in his determination that because Nuuanu Hale had attended to Client A's respiratory infection, Nuuanu Hale provided Client A with the requisite level of care, despite the fact that Nuuanu Hale failed to monitor and clean Client A's foley catheter. ROA 10.

E. The hearing officer erred in his determination that DHS' confirmation of neglect was based on an incomplete record; the hearing officer incorrectly assumed that DHS did not have access to Nuuanu Hale's Daily Chart (ROA 66, 67) at the time DHS made its determination.

F. The hearing officer committed reversible error because the substantial evidence in the record supports DHS' determination of neglect; Nuuanu Hale failed to prove by a preponderance of the evidence that DHS' determination was incorrect.

II. STATEMENT OF FACTS.

Client A, a seventy-nine year old female, dependent adult, had been a resident at the Nuuanu Hale nursing home facility for about fourteen years. Record on Appeal (ROA) at 127. Client A had a foley catheter inserted into her urethra since August 13, 2003 due to excoriation (irritation, red in color) around the buttocks. ROA 168. Client A was a victim of multiple strokes, suffered from dementia, diabetes, incontinence of the bladder and bowel, and according to Nuuanu Hale, was "a lady who was fragile to a great extent." Transcript of Hearing Regarding Nuuanu Hale Held on February 22, 2005 and March 22, 2005 ("TR ") page 17, lines 14-18. Client A also had bullous pemphigoid, "a very common blistering condition seen in **elderly** patients." ROA 54, 192.

On March 5, 2004, at about 12:45 p.m., Client A was taken from Nuuanu Hale by ambulance to the emergency room at St. Francis Medical Center for respiratory distress. ROA 127, 164. Client A died at St. Francis the next day, March 6, 2004. ROA 128.

On March 9, 2004, the St. Francis emergency room physician ("ER Physician ") contacted DHS with concerns about the condition of Client A's vaginal area due to the prolonged used of Client A's foley catheter. The ER Physician noted:

- Severe vaginal lesion with discharge and skin necrosis,
- The "whole" vaginal area reported to be "enlarged and pussy,"
- Two possible holes in the urethra, and
- Sepsis (infection in blood or tissues).

ROA 127-128. A "lesion" is an abnormal change in the structure of the skin. TR 13, lines 17-18. "Skin necrosis" is the death of skin tissue (black in color). TR 13, lines 19-20. The ER Physician indicated that Client A's infected vaginal area raised concerns about the apparent lack of proper care in the vaginal area and the foley catheter site [1] . ROA 128. The ER Physician diagnosed Client A with sepsis (infection in blood or tissues), bilateral pneumonia, multiple organ failure, and severe vaginal lesion with discharge and skin necrosis. ROA 128. The ER Physician indicated that the exact cause of the sepsis was unknown, but that it was possibly due to the bilateral pneumonia or the vaginal lesion. [2] ROA 128.

On March 10, 2004, a DHS social worker and a DHS registered nurse (RN) met with staff at Nuuanu Hale to discuss Client A's care and to review Nuuanu Hale's records. ROA 130, 157, 160-169. The Nuuanu Hale Administrator and the Director of Nursing informed DHS that the registered nurses and licensed practical nurses were responsible for foley care every shift; that there was no documentation by staff noting that foley care was provided on each shift, but that it was left to the staff person's discretion to document foley care in the progress notes. ROA 131. Nuuanu staff informed DHS that Dr. Lum, Client A's primary care physician, ordered a foley catheter for Client A because Client A was incontinent and the foley catheter prevented urine from contacting Client A's excoriated skin. ROA 131. Nuuanu Hale has over a hundred residents, and at the time of Client A's demise, only about three other residents had foley catheters. TR 76.

According to the Nuuanu Hale RN who worked with Client A regularly, Client A did have some swelling and redness to her vaginal area but no infection; she did not notice any pus or necrotic tissue in Client A's vaginal area. ROA 131. The Nuuanu Hale RN worked the day shift and therefore would be the one to perform foley care on Client A, which she stated she did daily, but did not document it in the chart. ROA 131. The Nuuanu Hale RN did not document the swelling and redness that she observed in Client A's vaginal area. ROA 160-164.

The lack of documentation of foley care concerned the DHS registered nurses because it is a nursing "basic rule of thumb," learned in nursing school, that if it is "not documented," then it was "not done. ROA 130, 131, TR 38, 40, 75.

Nuuanu Hale's Progress Notes covered Client A's last five days of her stay at Nuuanu Hale. ROA 160-164. It appears from the Progress Notes that Nuuanu Hale had been diligent in monitoring and noting Client A's vital signs and respiratory condition. ROA 160-164. Client A was given Tylenol for her fever, which ranged from 97.8 to 102.8, and Levaquin for her respiratory infection, she was suctioned at her mouth to remove mucous from her lung, and she was placed on oxygen. ROA 160-164. Absent from Nuuanu Hale's Progress Notes was any indication that Nuuanu Hale had checked Client A's vaginal area and foley catheter for possible infection. ROA 160-164.

A foley catheter is a tube inserted into the urethra (urinary tract) used to drain urine from the bladder. TR 8. The insertion of a foley catheter is an invasive procedure that causes the urethra to be highly susceptible to infection. TR 76, 77. Nuuanu Hale's instructions on “Foley Catheter Care and Maintenance,” states

[a] foley catheter is a potential source of infection. Factors which enhance the possibility of infection when a foley catheter is in place:... poor hygiene... Care and maintenance of the foley catheter are geared to minimize the above factors.

ROA 157. Nuuanu Hale's instructions specifically require:
i) “Daily hygiene.”

ii) “Cleanse external meatus (opening of urethra) with soap and water and swab with Betadine at least daily and PRN (pro re nata means “as needed “). INCLUDE THE OUTSIDE OF THE CATHETER.”

iii) “Clean from catheter on outward. NEVER WIPE TOWARDS THE MEATUS.”

ROA 157.

Back on August 13, 2003, Client A's primary care physician, Dr. Lum, ordered a foley catheter be inserted in Client A for “3 months or until [Client A's] buttocks excoriation healed.” ROA 55, 168. Six months later on February 20, 2004, Dr. Lum ordered Nuuanu Hale to “renew use of indwelling foley catheter [for] 3 months.” ROA 169. Upon being admitted to the St. Francis emergency room on March 5, 2004, Client A had a foley catheter inserted into her urethra for over six months.”

On March 11, 2004, the First Deputy Medical Examiner (“ME”) of the Department of the Medical Examiner conducted an autopsy on Client A. ROA 136. The autopsy report stated the following:

> BRIEF HISTORY: The decedent is a 79-year old Filipino female nursing home resident with a history of non-insulin dependent diabetes mellitus, hypertension, dementia, remote stroke, and mastectomy for breast cancer. She was taken to a local emergency room on the day prior to demise because of diminished sensorium and hypotension. The ER noted that her Foley catheter appeared dirty and her perineum appeared infected. Nursing home records indicated the same catheter had been indwelling for about three months.

ROA 136. The ME's FINDINGS/PATHOLOGIC DIAGNOSIS was, in part:
1. Laceration and perforation of the distal urethra along the site of Foley bladder catheterization with necrosis and abscess formation (pocket of pus) of the urethral wall.

2. Generalized perineal edema (swelling) and inflammation with purulent [pus] exudates (discharge).

ROA 136, 177 (photo). Under EVIDENCE OF INJURY the ME noted: Perineal skin and soft tissue is diffusely markedly edematous and erythematous [swelling and redness spread in all areas]. Drops and threads of pus-like material are adherent to skin and hair of the perineum and adjacent bilateral inner thighs. The labia majora (outer lips of vagina) are markedly and

diffusely edematous and erythematous. Prominent deposits of pus-like material adhere to mucosa (mucus producing tissue) of inner surfaces of the labia majora. The labia minora (inner lips of vagina) are markedly diffusely edematous and erythematous. Pus-like material is present in the vagina and cervical canal. Periurethral tissue is markedly edematous, erythematous, softened, and necrotic-appearing. The urethral orifice is dilated and there is a 0.4 cm irregular transmural laceration of the distal urethral wall (a tear through the wall of the urethra) near the urethral orifice. Tissue surrounding the urethral orifice and urethral wall laceration has the appearance of pus infiltration with abscess formation.

ROA 141. The ME concluded that:

> Based on these autopsy findings and the investigative and historical information available to me, in my opinion, this 79-year old woman died as a result of sepsis, most likely originating from an infected urethral perforation associated with prolonged urinary bladder catheterization... . The manner of death is categorized as undetermined since it is unclear whether her perineal and other care conformed to general nursing care standards and to local nursing care guidelines at the nursing home. It is also unclear how much the decedent's diabetes and generalized debility predisposed her to infection.

ROA 137-138. CAUSE OF DEATH was listed as:
a) Sepsis

Due to, or as a consequence of:

b) Infected urethral perforation associated with prolonged urinary bladder catheterization.

ROA 138. The ME listed "**elder** neglect" and arteriosclerotic cardiovascular disease as a contributing cause. ROA 138.

On March 12, 2004, the DHS RN spoke with Norman Goldstein, M.D., a dermatologist who had begun treating Client A in January 2003 for "a widespread dermatophyte infection and nummular dermatitis" (fungal infection where skin is inflamed) ROA 132, 192. Dr. Goldstein stated that Client A also had bullous pemphigoid, a disease that can cause blistering and possibly skin necrosis, and can appear anywhere on the body. ROA 132. It is not noted where on Client A's body the dermatophyte infection, nummular dermatitis, and bullous pemphigoid appeared, but Dr. Goldstein indicated that he had never examined Client A's genital area. ROA 132.

On March 12, 2004, the DHS RN spoke with Steven M. C. Lum, M.D., Client A's primary care physician. ROA 132. Dr. Lum indicated that he had not seen Client A's genital area for at least six months. ROA 132. However, Dr. Lum indicated that the condition of Client A's genital area, as reported to DHS by the ER Physician, may have been due to her disease process. ROA 132. Upon being informed that Nuuanu Hale staff were unaware of the infection to Client A's genital area, Dr. Lum indicated that there may not have been clinical signs for the staff to notice. ROA 132.

Based on Client A's severely infected vaginal area with pus and skin necrosis; Client A's "dirty" foley catheter; the concerns raised by the ER Physician; the ME's autopsy report; and the fact that Nuuanu Hale had failed to observe and note Client A's severely infected vaginal area with pus and skin necrosis, DHS confirmed that Nuuanu Hale had neglected Client A by failing to exercise proper care. ROA 111. [3]

Nuuanu Hale requested an administrative hearing to dispute DHS' confirmation of neglect. The administrative hearing was held on February 22, 2005 and March 22, 2005. DHS was represented by Jolaine Hao, DHS registered nurse and Program Specialist; Neuman Kwong, DHS Adult Protective Services registered nurse; Matthew Chung, DHS Adult Protective Services social worker; David Tanaka, DHS Adult Protective Services Supervisor; Linda Chun, DHS Program Specialist, Adult Community Care Services Branch; and Deputy Attorney General Candace Park. Nuuanu Hale was represented by attorneys John Bain and

Kapono Kiakona, and expert witness James Navin, M.D. Nuuanu Hale submitted letters from Client A's treating physicians, Drs. Lum and Goldstein and from Nuuanu Hale's certified nurses assistants.

On October 31, 2005, the hearing officer issued his decision reversing DHS' confirmation of neglect by Nuuanu Hale of Client A. ROA 9. DHS appealed the hearing officer's decision to this Court.

III. STANDARD OF REVIEW.

The standard of review is established in Hawaii Revised Statutes ("HRS ") section 91-14(g), which provides:
(g) Upon review of the record the court may affirm the decision of the agency or remand the case with instructions for further proceedings; or it may reverse or modify the decision and order if the substantial rights of the petitioner may have been prejudiced because the administrative findings, conclusions, decisions, or orders are:

(1) In violation of constitutional or statutory provisions; or

(2) In excess of the statutory authority or jurisdiction of the agency; or

(3) Made upon unlawful procedure; or

(4) Affected by other error of law; or

(5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) Arbitrary, or capricious, or characterized by **abuse** of discretion or clearly unwarranted exercise of discretion.

§ 91-14(g), HRS (1993).

Conclusions of law are reviewable under subsections (1), (2), and (4); questions regarding procedural defects are reviewable under subsection (3); findings of fact are reviewable under subsection (5); and an agency's exercise of its discretion is reviewable under subsection (6). *Paul's Electrical Service, Inc. v. Befitel*, 104 Haw. 412, 91 P.3d 494 (2004) (citations omitted).

IV. ARGUMENT.

DHS respectfully requests this Court to reverse the hearing officer's decision because (i) the reliable, probative, and substantial evidence in the record supports DHS' determination that Nuuanu Hale failed to provide Client A with the degree of care a reasonable caregiver would have provided; (ii) there is insufficient evidence to support the hearing officer's determination that the nursing staff recorded any abnormalities regarding Client A's vaginal area; (iii) there is insufficient evidence to support the hearing officer's determination that Client A's vaginal infection was a bullous pemphigoid flare-up that came on so rapidly that it was not observable by Nuuanu Hale; (iv) that although Nuuanu Hale may have properly attended to Client A's respiratory infection, Nuuanu Hale failed to properly attend to Client A's foley catheter and infected vaginal area; (v) DHS did not base its determination of neglect on an incomplete record; and (vi) Nuuanu Hale failed to prove by a preponderance of the evidence that DHS' determination of neglect was incorrect.

A. Nuuanu Hale Neglected to Provide Client A with the Proper Level of Care.

Nuuanu Hale failed to exercise the degree of care that a reasonable caregiver would exercise for a dependent adult in Client A's condition.

Pursuant to HRS section 346-222, **abuse** occurs where

> [t]here has been a failure to exercise that degree of care toward a dependent adult which a reasonable person with the responsibility of a caregiver would exercise, including, but not limited to, failure to (A) Assist in personal hygiene... (C) Provide necessary health care.

HRS § 346-222 (1993).

It is undisputed that Client A was "a lady who was fragile to a great extent." Nuuanu Hale's expert witness testified that Client A, having had a foley catheter inserted in her urethra "for months," was "readily susceptible to trauma, infection." TR 32. This fact alone would cause the reasonable caregiver to be diligent in ensuring Client A's vaginal area and foley catheter were kept clean and free of infection.

Add to the fact that Client A had a foley catheter inserted in her urethra for over six months, the fact that Client A had a history of diabetes and bullous pemphigoid, the reasonable caregiver would have been extra diligent with respect to the care and monitoring of Client A's vaginal area and foley catheter.

Add to the fact that Client A had a foley catheter inserted into her urethra for over six months and Client A had a history of diabetes and bullous pemphigoid, the fact that during the last five days of Client A's life Client A was running a fever with temperatures of 102.2, 100, 101, 102.8, 100, 101.2, 100.9, 100.3, 100.6, 100.9, 100.6, 100.4, the reasonable caregiver would have closely monitored Client A's vaginal area and foley catheter site for infection. ROA 160-164.

1. *Foley Care.* The industry standard for proper foley care is (i) daily cleansing and monitoring for infection, and (ii) documentation. TR 38, 66. The daily cleansing requires using Betadine on a swab and going all the way up to where the foley catheter inserts into the meatus, the portal of entry into the urethra, and cleaning outward. TR 76, 77. Foley care is a very specific procedure because the foley catheter must be kept very clean to prevent infection. TR 77. The procedure described in Nuuanu Hale's "Foley Catheter Care and Maintenance," requires daily cleansing of the external meatus and the outside of the catheter with soap and water and swabbing with Betadine, but fails to require that foley care be documented.

The ER Physician who personally examined Client A upon her admission to St. Francis emergency room, and the Medical Examiner who performed the autopsy of Client A, the only two doctors who had personally observed Client A, noted:

- "Drops and threads of pus-like material" clinging to Client A's pubic hairs, genital area, and both sides of her inner thighs;
- A swollen, pussy, red colored, structurally abnormal labia; and
- A perforated and pussy urethra.

Client A's vaginal area was so grossly infected that it caused both physicians to question whether Nuuanu Hale had provided Client A with proper foley care and perineal care[4]; that it was "unclear whether her perineal and other care conformed to general nursing care standards and to local nursing care guidelines at the nursing home." ROA 138.

The Nuuanu Hale RN responsible for Client A's foley care indicated she did foley care on a daily basis during the 7 a.m. to 3 p.m. day shift. ROA 131. However there is no documentation to prove that foley care was provided daily. Had the Nuuanu Hale RN followed Nuuanu Hale's instructions on "Foley Catheter Care and Maintenance," the Nuuanu Hale RN should have opened up the vaginal area and cleaned the entire area, including the foley catheter site, wiping from the point of contact with the body outwards, on a daily basis. Client A's infected vaginal area and infected urethra could have been prevented or at the very least, the lesion, pus, swelling, and skin necrosis should have been observed and noted.

2. Foley Intact/Patent Does Not Indicate Foley Care.

The last 6 days of Nuuanu Hale's Progress Notes regarding Client A indicate "foley intact/patent urine out of adequate with hematuria noted one time during week;" "foley intact and patent-urine cloudy;" "foley catheter intact and patent." Nuuanu Hale's expert witness, Dr. Navin, contends that these entries indicate that foley care was provided. Dr. Navin's opinion contradicts the statements of Nuuanu Hale's charge nurse and registered nurse who indicated that foley care was not always documented. ROA 130-131.

A report that the foley is intact and patent does not mean that the foley catheter port of entry into the urethra was examined. A foley catheter is inserted into the urethra, a tube comes from the foley catheter and is taped to the leg and ends at a bag. A report that the foley is intact and patent simply means that the urine is draining and collecting in the bag. TR 79. One could determine a foley is intact simply by looking at the tube draining into the bag. TR 78, 80. Therefore, the fact that Nuuanu Hale's Progress Notes indicate the foley was intact and patent does not prove that Nuuanu Hale properly cleansed and monitored Client A's foley catheter.

B. Hearing Officer Erred in His Determination that the Nurses Monitored Client A's Vaginal Area.

The hearing officer's determination that "[t]his evidence and testimony supports [Nuuanu Hale's] position that the nursing staff observed and recorded any abnormalities with respect to Client A's genital and perineal area," is clearly erroneous. The hearing officer based his finding on (i) the fact that the Daily Chart and letters written by the certified nurses assistants indicate that Client A was given a bed bath in the days prior to being admitted to St. Francis emergency room, and (ii) that the "nursing staff at Nuuanu Hale observed and recorded a rash on Client A's buttocks that spread to her genital area the day before admittance to St. Francis Hospital." ROA 22. The hearing officer is wrong because (i) Nuuanu Hale nursing staff failed to perform the proper bed bath/perineal care on Client A as described in Nuuanu Hale's procedures "Helping a Person With a Complete Bed Bath;" and (ii) Client A's rash did not spread to her vaginal area; rather the Progress Notes indicate that Client A's rash spread to her groin area.

1. Nuuanu Hale Failed to Perform Proper Perineal Care During Bed Bath. Nuuanu Hale submitted letters from its certified nurses assistants indicating that in the final 8 days of Client A's life, from February 25 to March 5, 2004, Client A's perineal area was washed and dried. ROA 58-62. These letters were based on Nuuanu Hale's Daily Charts that indicate that Client A was given a bed bath during the 7 a.m.- 3 p.m. day shift on March 2, 3, 4, and 5, 2004. ROA 66. According to Nuuanu Hale's "bed bath" procedures, staff are required to "elevate her pelvis by placing either a bedpan or a folded towel or bath blanket under her buttocks... separate the labia with one hand, wash one side of her labia in one gentle stroke, then, using a different part of the wash cloth, wash the other side... rinse her perineal area by using the same steps... dry her perineal area... using the same steps." ROA 75.

In Client A's case, because Client A had a foley catheter, in addition to separating the labia and washing each side, the reasonable caregiver would have to proceed carefully while performing the bed bath/perineal care, watching to ensure that he or she did not dislodge the foley catheter tube sticking out from the urethra.

Here, the evidence indicates that Client A was given a bed bath on March 2, 3, 4, and 5, 2004. Had Nuuanu Hale staff performed the proper bed bath/perineal care on Client A by separating the labia and watching to make sure the foley catheter was not dislodged, they surely would have noticed Client A's severely infected vaginal area with pus and skin necrosis.

On March 5, 2004, Client A was given a bed bath during the 7a.m. to 3 p.m., day shift. ROA 67. On March 5, 2004, Client A was taken from Nuuanu Hale by ambulance at 12:45 p.m. to the St. Francis emergency room where the ER Physician observed Client A's vaginal area to be severely infected with pus and skin necrosis, and Client A's foley catheter to be dirty. ROA 128, 164. Had the certified nurses assistant who performed the bed bath/perineal care on Client A on March 5, 2004 between 7 a.m. and 12:15

p.m. performed a proper bed bath by separating the labia and watching to make sure the foley catheter did not dislodge, that certified nurses assistant certainly would have observed Client A's severely infected vaginal area with pus and skin necrosis.

Additionally, the letters written by the certified nurses assistants are unreliable to prove foley care was provided. The Nuuanu Hale Administrator and the Director of Nursing indicated that the registered nurses and licensed practical nurses were responsible for foley care, not the certified nurses assistants. Therefore, these letters do not indicate that proper foley care was provided. Finally, the letters are not credible as they were written over a year after Client A's death, and appear to have been written for the sole purpose of the administrative hearing. [5]

The hearing officer erred in assuming that just because there was documentation that Client A's perineal area had been washed and dried, that Client A's vaginal area and foley catheter had been examined at the point the foley entered the body to check for infection. The Daily Chart and the letters written by the certified nurses assistants do not support the hearing officer's finding that Client A's infected vaginal area was “not observable“ by Nuuanu Hale. Rather, it supports DHS' finding that Client A's infected vaginal area was “not observed“ by Nuuanu Hale, but should have been observed.

2. *Groin Not Same as Vaginal Area.* There is nothing in the record that indicates that the rash on Client A's buttocks spread to Client A's genital area. The entry for the weekly summary on March 4, 2004, indicates that Client A's rash was on Client A's groin (area between the crease of the thigh and the trunk of the body), not her genital area. ROA 131. Dr. Navin also indicated that the weekly summary noted that the rash was more pronounced on the groin. TR 22. The groin area is not by any means synonymous with the vaginal area, and if Nuuanu Hale staff looked at Client A's groin, they would not necessarily see her labia as it is entirely possible for the groin to be observed without observing the vaginal area. TR 65.

Finally, the Nuuanu Hale staff did not note everything they observed with respect to Client A. Upon being questioned by DHS, the Nuuanu Hale registered nurse who was responsible for Client A's foley care indicated that she had observed redness and swelling to Client A's vaginal area. ROA 131. However, this was not noted in the Progress Notes. ROA 160-164.

Based on the foregoing, it is clear that the evidence the hearing officer relied upon to support his determination that Client A's infected vaginal area was “not observable“ was unreliable and therefore the hearing officer committed reversible error. TR 65.

C. Client A's Vaginal Infection Should Have Been Observed by Nuuanu Hale.

The hearing officer erred in his determination that “[t]he objective evidence and testimony from Client A's treating doctors, attending nurses and [Nuuanu Hale's] expert witness is credible” and that the “swift deterioration of Client A's condition due to an extremely weak immune system [that] permitted the Bullous Pemphigoid to spread at a rapid rate and result in purulent and necrosis at the time Client A entered St. Francis hospital on March 5, 2004.”

Implied in the hearing officer's decision is that Client A's vaginal area became infected within a matter of hours and that Client A's infected vaginal area was not due to any neglect on Nuuanu Hale's part, but instead was due to a rapid flare-up of the bullous pemphigoid. The hearing officer is wrong; (i) The evidence offered by Nuuanu Hale is unreliable; (ii) Client A's infected vaginal area was not the result of a bullous pemphigoid flare-up; (iii) If Client A's infected vaginal area was due to bullous pemphigoid, the blisters should have been apparent to Nuuanu Hale staff; and (iv) Client A's infected urethra was not a result of Client A being transported to the emergency room while on the foley catheter.

1. *Nuuanu Hale's Evidence Is Not Credible.* The testimony and letters of Nuuanu Hale's expert witness, Dr. Navin; Client A's dermatologist, Dr. Goldstein; Client A's primary care physician, Dr. Lum; and Client A's attending nurses and certified nurses assistants lack credibility.

Dr. Navin was hired by Nuuanu Hale as an expert witness. Drs. Goldstein and Lum were Client A's treating physicians; neither would appreciate a determination that his patient had been a victim of caregiver neglect as the caregiver operates under the treating physicians' orders.

More importantly, although Dr. Navin indicated he reviewed Nuuanu Hale's records and went to the Medical Examiner's office and reviewed the autopsy report and slides of the tissue samples, neither Dr. Navin, Dr. Goldstein or Dr. Lum had personally examined Client A's infected vaginal area upon being admitted to the St. Francis emergency room or upon her demise. The ER Physician and the Medical Examiner were the only physicians who had personally examined Client A's severely infected vaginal area with pus and skin necrosis.

The opinions of Drs. Navin, Goldstein and Lum were pure speculation and solicited for purposes of this administrative appeal. As indicated in the prior section of this brief, the statements and letters submitted by the Nuuanu Hale nursing staff and certified nurses' assistants are unpersuasive. There is no documentation that foley care was provided; the only other relevant evidence, Client A's severely infected vaginal area with pus and skin necrosis, clearly supports the ER Physician's and Medical Examiner's opinions, and DHS' position, that foley care was not provided.

Additionally, Dr. Navin was wrong in concluding that Client A developed a yeast infection. ROA 180. According to DHS' registered nurse, the culture of the vagina showed enterococcus faecalis and Escherichia coli, bacteria. TR 56, ROA 153. If Client A had a yeast infection, the forensic evidence would have showed candida, which is yeast. TR 56. The forensic evidence did not show yeast. TR 56.

2. *Not Bullous Pemphigoid.* Dr. Goldstein indicated that bullous pemphigoid could occur in the vaginal area and that "bullous pemphigoid lesions can appear very rapidly and the bullae can become necrotic within a short time." ROA 54, ROA 192-193. Dr. Navin opined, and Dr. Lum concurred, that the ER Physician and Medical Examiner could have mistaken the vaginal lesion as a sign of neglect, when in fact it was a flare-up of the bullous pemphigoid. TR 36, ROA 55, 56.

Dr. Navin described bullous pemphigoid as

> shaggy-looking... not little blisters; these are big blisters, and then they become necrotic and the tissue sloughs off the surface. And it's not unusual for them to get infected, and they look awful... and [ER Physician] could easily interpret this as evidence that no one was caring for this lady's skin.

TR 35-36.

The preponderance of the evidence does not support Nuuanu Hale's contention. There was no documentation to support Nuuanu Hale's claim that Client A had suffered from a bullous pemphigoid flare up on the day of her demise. Neither the ER Physician nor the Medical Examiner, the only two physicians who had examined Client A's body during the relevant time period noted any "shaggy-looking big blisters" anywhere on Client A's body. Also, bullous pemphigoid gives off a clear drainage, not a purulent (pussy) drainage. TR 67. The ER Physician and the Medical Examiner both reported the presence of pus in Client A's vaginal area, not clear drainage.

When asked by the DHS RN whether there was any documentation to support his opinion that the bullous pemphigoid manifested itself in Client A's vaginal area, Dr. Navin incorrectly indicated that there was documentation that Client A had rash on her buttocks. TR 36. However, the rash on Client A's buttocks was not bullous pemphigoid, but was a result of Client A's incontinence. ROA 55, 168.

3. *If it Was Bullous Pemphigoid, Nuuanu Hale Should Have Noted It.* In a March 14, 2005 letter to Nuuanu Hale's legal counsel, Dr. Goldstein stated "sometimes the bullae can develop in a matter of hours." ROA 54. Dr. Lum indicated that it was his belief that in "the last several days of [Client A's] stay at Nuuanu Hale, [t]he pneumonia, sepsis and out of control diabetes led to an

acute flare of [Client A's] bullous pemphigoid causing not only severe deterioration of her integument, but the lesions involving her vulva and vagina. ROA 55. According to Dr. Lum, Client A's bullous pemphigoid flared-up "in the last several days of [Client A's] stay at Nuuanu Hale. When asked to give an opinion as to how long Client A's vagina and urethra were infected, Dr. Navin answered "maximum seventy-hours, more likely twenty-four. TR 35.

These statements by Drs. Goldstein, Lum, and Navin are unreliable for the following reasons:

First, Dr. Goldstein's opinion that "sometimes bullae can develop in a matter of hours" is the same as if Dr. Goldstein had stated, "sometimes bullae may not develop in a matter of hours." In any case, if Client A suffered from a bullous pemphigoid flare-up and the bullae developed in a matter of hours, the ER Physician and the Medical Examiner would have observed bullous pemphigoid blisters; instead they observed:

- "Drops and threads of pus-like material" clinging to Client A's pubic hairs, genital area, and both sides of her inner thighs;

- a swollen, pussy, red colored, structurally abnormal labia; and

- a perforated and pussy urethra.

Although Dr. Goldstein indicated in his February 18, 2005 letter to Nuuanu Hale's legal counsel that "bullous pemphigoid lesions can appear very rapidly and the bullae can become necrotic within a short time," if Client A had experienced a bullous pemphigoid flare-up in her vaginal area and if the bullous pemphigoid became necrotic, Nuuanu Hale staff should have observed and noted the presence of bullous pemphigoid when they performed foley care or bed bath/perineal care on Client A. Nuuanu Hale's Progress Notes are void of any entry indicating that Client A's bullous pemphigoid had flared-up and became infected and necrotic. ROA 160-164.

Second, at part II of the hearing on March 22, 2005, DHS addressed Dr. Lum's statement that "the entire picture rapidly developed in only a matter of days." ROA 56. DHS indicated that if Dr. Lum's speculation was true, then Nuuanu Hale should have observed the bullous pemphigoid flare-up. At the very least, the ER Physician and the Medical Examiner should have observed bullous pemphigoid blisters. Nuuanu Hale's legal counsel argued that Dr. Lum was "talking about the entire picture ... she didn't develop diabetic acidosis in a moment's time...[i]n fact most of the disease process would not be observable interiorly." TR 61, 62. Dr. Lum did not examine Client A's severely infected vaginal area and Nuuanu Hale's legal counsel is not a medical doctor. This evidence is unreliable.

Third, according to Dr. Navin, the pus in Client A's vaginal area and urethra was present for "seventy-hours, more likely twenty-four" hours. TR 35. This is Dr. Navin's opinion, based on his review of the Medical Examiner's autopsy report and the slides of tissue samples. Dr. Navin did not personally examine Client A's severely infected vaginal area with pus and skin necrosis or the perforation in Client A's urethra. Dr. Navin never examined Client A. The ER Physician and the Medical Examiner personally examined Client A's severely infected vaginal area with pus and skin necrosis, and Client A's perforated and infected urethra. If both the ER Physician and the Medical Examiner believed that Client A's grossly infected perineal could not have been noticed by Nuuanu Hale or could not have been prevented by Nuuanu Hale, neither the ER Physician or the Medical Examiner would have questioned the level of care provided by Nuuanu Hale.

4. Perforation In Urethra. Nuuanu Hale contends that the perforation in Client A's urethra happened while Client A was being transported from Nuuanu Hale to the St. Francis emergency room. The Medical Examiner indicated that Client A's "sepsis" "most likely" originated from "an infected urethral perforation associated with prolonged urinary bladder catheterization." ROA 137-138. The Medical Examiner personally examined the infected perforation in Client A's urethra. Drs. Navin, Lum, and Goldstein did not. Also, Client A's infected urethral perforation was a bacterial infection; bacteria does not normally develop in just a few hours; and the bacteria that was in Client A's vagina and cervix was identical to the bacteria in Client A's blood. TR 66, 71.

The only reliable evidence in the record that clearly answers the question of whether proper foley care was provided is the undisputed condition of Client A's severely infected vaginal area with pus and skin necrosis.

D. Nuuanu Hale Failed to Properly Monitor Client A's Foley Catheter.

The hearing officer erred in his determination that "the nursing staff at Nuuanu Hale properly monitored Client A and contacted physicians when her health began to fail, and made proper arrangements to transfer Client A to St. Francis Hospital when her medical condition further deteriorated." ROA 10.

The hearing officer is wrong. Nuuanu Hale may have properly attended to Client A's respiratory infection, but Nuuanu Hale failed to properly monitor and care for Client A's foley catheter, resulting in a severely infected vaginal area.

As previously indicated, Client A, approximately one of four residents out of 100 who was on a foley catheter, required a heightened level of care by the caregiver because the point where the foley catheter enters the body is highly susceptible to infection. The reasonable caregiver would have been extra diligent in monitoring Client A's foley catheter, especially when she started showing signs of elevated temperatures. Instead, Nuuanu Hale's legal counsel indicated that

> what we're saying is on the last day, this lady was - they were trying to get her out to get her treated for a life-threatening disease, which ultimately did take her life. And quite honestly, peri [perineal] care was the last thing on everybody's mind who was trying to keep her alive on that day.

TR 69.

Nuuanu Hale's legal counsel assumes the cause of Client A's death was not "sepsis, due to or as a consequence of Client A's infected urethral perforation associated with prolonged urinary bladder catheterization," as indicated by the Medical Examiner who personally performed an autopsy on Client A's body. ROA 138. Nuuanu Hale did not present any evidence to support its claim that the Medical Examiner had erred in this determination.

Also, Nuuanu Hale's legal counsel ignores the fact that according to the Progress Notes, Client A's temperature began to spike on March 1, 2004; that an elevated temperature is a sign of infection, and that, for a patient with a foley catheter, the first place to check for an infection is the foley catheter site. In Client A's case, because her temperature had been elevated for several days, Nuuanu Hale should have been closely monitoring Client A's foley catheter for signs of infection.

E. DHS Confirmed Neglect Based On All Relevant Facts.

The hearing officer erred in his determination that DHS' confirmation of neglect was based on an incomplete record. Subsequent to the completion of the administrative hearing on March 22, 2005, Nuuanu Hale submitted additional exhibits, post-hearing. These post-hearing exhibits were addressed by DHS in an April 15, 2005, post-hearing memorandum to the hearing officer. ROA 25-27.

Of the exhibits submitted by Nuuanu Hale post-hearing, the only relevant exhibits were Nuuanu Hale's Daily Chart for February 25, 2004 to March 5, 2004 (ROA 66, 67) and the "Helping a Person with a Complete Bed Bath" procedures. DHS did in fact review and rely upon Nuuanu Hale's Daily Chart when it confirmed neglect by Nuuanu Hale. The Daily Chart supported DHS' finding that Nuuanu Hale had failed to provide proper foley care and perineal care to Client A, especially in the last five days of Client A's stay at Nuuanu Hale.

F. Nuuanu Hale Failed to Meet its Burden.

Pursuant to HRS section 91-10(5), "the party initiating the proceeding shall have the burden of proof, including the burden of producing evidence as well as the burden of persuasion. The degree of quantum of proof shall be a preponderance of evidence." HRS § 91-10(5) (Supp 2004). Nuuanu Hale, the party who requested the administrative hearing, had the burden of proving, by a preponderance of evidence, that DHS' determination of neglect was improper. Nuuanu Hale did not meet its burden.

Here, the substantial evidence in the record indicates that Client A had a severely infected vaginal area with pus and skin necrosis, and a perforated, infected urethra, that she had a foley catheter inserted into her urethra for over six months, and that the ER Physician and the Medical Examiner were extremely concerned over the care Nuuanu Hale had provided Client A with respect to her foley catheter and her entire perineal area. These facts are not in dispute.

The hearing officer erred by disregarding the findings and concerns of the ER Physician and the Medical Examiner, the only two physicians who had personally examined Client A's body and in particular Client A's infected vaginal area just prior and subsequent to Client A's demise, and by relying on the speculation of Drs. Navin, Goldstein, and Lum, who did not.

V. CONCLUSION.

The hearing officer clearly erred in reversing DHS' determination that Nuuanu Hale had failed to provide Client A with the level of care a reasonable caregiver would have provided. As such, DHS respectfully requests this Court to grant DHS' appeal and reverse the hearing officer's decision.

DATED: Honolulu, Hawaii, March 1, 2006.

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Footnotes

1 Port where foley catheter enters the urethra.

2 The Medical Examiner indicated that Client A "died as a result of sepsis, most likely originating from an infected urethral perforation associated with prolonged urinary bladder catheterization." ROA 137-138.

3 DHS' determination was based on the condition of Client A's vaginal area, not on Client A's death.

4 For females, the perineal is the area between the pubic bone and the anus.

5 The letters dated March 14, 2004 found on pages 57 and 60 of the record should be dated March 14, 2005. See TR 43.

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